Anthem

Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
BluePreferred for Individuals Plans

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but the patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK		OUT-OF-NETWORK	
4. Deductible Type[2]	Benefit Year		Benefit Year	
4. ANNUAL DEDUCTIBLE[2a]	Dollar amount below excludes copayments.			
	Individual[2b]	**Family[2c]**	**Individual**	**Family**
25-500D/1000-80% plan	$500	$500 per family member	$1,000	$1,000 per family member
25-1000D/1000-80% plan	$1,000	$1,000 per family member	$2,000	$2,000 per family member
25-2000D/1000-80% plan	$2,000	$2,000 per family member	$4,000	$4,000 per family member
25-500D/2000-80% plan	$500	$500 per family member	$1,000	$1,000 per family member
25-1000D/2000-80% plan	$1,000	$1,000 per family member	$2,000	$2,000 per family member
25-2000D/2000-80% plan	$2,000	$2,000 per family member	$4,000	$4,000 per family member
3000D/2000-80% plan	$3,000	$3,000 per family member	$6,000	$6,000 per family member
5. OUT-OF-POCKET ANNUAL MAXIMUM[3]	Dollar amount below excludes deductible and copayments. The out-of-pocket annual maximum does not include coinsurance for Other Mental Health Care.			
	a) Individual	b) Family	a) Individual	b) Family
25-500D/1000-80% plan	$1,000	$1,000 per family member	$2,000	$2,000 per family member
25-1000D/1000-80% plan	$1,000	$1,000 per family member	$2,000	$2,000 per family member
25-2000D/1000-80% plan	$1,000	$1,000 per family member	$2,000	$2,000 per family member
25-500D/2000-80% plan	$2,000	$2,000 per family member	$4,000	$4,000 per family member
25-1000D/2000-80% plan	$2,000	$2,000 per family member	$4,000	$4,000 per family member
25-2000D/2000-80% plan	$2,000	$2,000 per family member	$4,000	$4,000 per family member
3000D/2000-80% plan	$2,000	$2,000 per family member	$4,000	$4,000 per family member
c) Is deductible included in the out-of-pocket maximum?	No	No	No	No
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$2,000,000 per member in- and out-of-network combined for all covered services. Morbid obesity surgery has a lifetime maximum benefit of $7,500 per member for services received from a Center of Excellence facility; total lifetime maximum shall not exceed $7,500 per member in- and out-of-network combined. Major organ transplants have a lifetime maximum of $1,000,000 per transplant per member.		$2,000,000 per member in- and out-of-network combined for all covered services. Morbid obesity surgery has a lifetime maximum benefit of $1,500 per member for services received from a facility that has not been designated as a Center of Excellence; total lifetime maximum shall not exceed $7,500 per member in- and out-of-network combined. Major organ transplants have a lifetime maximum of $1,000,000 per transplant per member.	

Independent licensees of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

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	IN-NETWORK	OUT-OF-NETWORK
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO Provider Network. See provider directory for complete list of current providers.	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes
8. MEDICAL OFFICE VISITS[4]		
For plans: 25-500D/1000-80% plan 25-1000D/1000-80% plan 25-2000D/1000-80% plan 25-500D/2000-80% plan 25-1000D/2000-80% plan 25-2000D/2000-80% plan	$25 copayment for office visit only. See line 9 for preventive services, which are limited.	40% coinsurance after deductible
For plan: 3000D/2000-80% plan	20% coinsurance after deductible. See line 9 for preventive services, which are limited.	40% coinsurance after deductible
9. PREVENTIVE CARE		
a) Children's services	20% coinsurance, not subject to deductible for age-appropriate visits and routine immunizations.	40% coinsurance, not subject to deductible for age-appropriate visits and routine immunizations.
b) Adults' services For plans: 25-500D/1000-80% plan 25-1000D/1000-80% plan 25-2000D/1000-80% plan 25-500D/2000-80% plan 25-1000D/2000-80% plan 25-2000D/2000-80% plan	Not covered except for: **Women:** • One annual pap exam - $25 copayment for office visit only. For the laboratory services that accompany the pap exam, Anthem limits benefit to $75, which is not subject to deductible or coinsurance. • Mammogram screening, which is not subject to deductible or coinsurance. • Colorectal cancer screenings, not subject to deductible (coinsurance applies). **Men:** • Prostate screening, which is not subject to deductible or coinsurance.	Not covered except for: • Mammogram screening and prostate screening, which are not subject to deductible or coinsurance. • Colorectal cancer screenings for men and women, not subject to deductible (coinsurance applies).
For plan: 3000D/2000-80% plan	Not covered except for: **Women:** • One annual pap exam – 20% coinsurance after deductible for office visit only. For the laboratory services that accompany the pap exam, Anthem limits benefit to $75, which is not subject to deductible or coinsurance. • Mammogram screening, which is not subject to deductible or coinsurance. • Colorectal cancer screenings, not subject to deductible (coinsurance applies).	Not covered except for: **Women:** • Mammogram screening, which is not subject to deductible or coinsurance. • Colorectal cancer screenings, not subject to deductible (coinsurance applies).

	IN-NETWORK	OUT-OF-NETWORK
	Men: • Prostate screening, which is not subject to deductible or coinsurance. • Colorectal cancer screenings, not subject to deductible (coinsurance applies).	**Men:** Prostate screening, which is not subject to deductible or coinsurance. Colorectal cancer screenings, not subject to deductible (coinsurance applies).
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care[5]**	 Not covered Delivery not covered. 20% coinsurance for inpatient well baby care.	 Not covered Delivery not covered. 40% coinsurance after deductible for inpatient well baby care.
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions** **a) Outpatient care**	Tier 1 generic formulary $15 copayment, tier 2 brand formulary $40 copayment, tier 3 non-formulary $60 copayment at a participating pharmacy up to a 34-day supply.	Not covered
b) Prescription Mail Service	Tier 1 generic formulary $30 copayment, tier 2 brand formulary $80 copayment, tier 3 non-formulary $120 copayment through the mail order service up to a 90-day supply. In addition to the cost sharing described above, if you purchase a brand-name drug when there is a FDA rated equivalent generic drug available, you are responsible for the Tier-2 and Tier-3 Copayment for brand-name drugs and you will pay the difference between the cost of the brand-name and the cost of the generic. For example: a Tier-3 brand-name prescription costs $50; a generic Tier-1 substitution is available, the generic prescription costs $20, you pay the $30 difference plus the Tier-3 Copayment. The $30 difference is not applied towards any other cost-sharing requirement. For drugs on our approved list, contact Customer Service at (888) 231-5046. Covered only when received from a participating pharmacy.	Not covered
12. INPATIENT HOSPITAL	20% coinsurance after deductible	40% coinsurance after deductible
13. OUTPATIENT/AMBULATORY SURGERY	20% coinsurance after deductible	40% coinsurance after deductible
14. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI, nuclear medicine and other high-tech services**	 20% coinsurance after deductible 20% coinsurance after deductible	 40% coinsurance after deductible 40% coinsurance after deductible
15. EMERGENCY CARE[7, 8]	20% coinsurance after deductible	40% coinsurance after deductible
16. AMBULANCE **a) Ground** **b) Air**	 40% coinsurance after deductible, up to a maximum benefit of $350. 40% coinsurance after deductible, up to a maximum benefit of $5,000.	 40% coinsurance after deductible, up to a maximum benefit of $350. 40% coinsurance after deductible, up to a maximum benefit of $5,000.

	IN-NETWORK	OUT-OF-NETWORK
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	20% coinsurance after deductible	40% coinsurance after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Biologically-Based Mental Illness Care is paid as Other Mental Health Care, see line 19.	Biologically-Based Mental Illness Care is paid as Other Mental Health Care, see line 19.
19. 0THER MENTAL HEALTH CARE		
a) Inpatient care	50% coinsurance after deductible. Limited to 45 full or 90 partial days per member in each benefit year, in- and out-of-network combined.	
b) Outpatient care	50% coinsurance after deductible, up to a maximum benefit of $500 per member in each benefit year, in-and out-of-network combined.	
	Maximum benefit for inpatient and outpatient care is limited to $10,000 per member per lifetime.	
20. ALCOHOL & SUBSTANCE ABUSE	Not covered	Not covered
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY		
a) Inpatient	20% coinsurance after deductible. Covered for inpatient rehabilitation therapy for up to 30 days per member in each benefit year, in- and out-of-network combined.	40% coinsurance after deductible. Covered for inpatient rehabilitation therapy for up to 30 days per member in each benefit year, in- and out-of-network combined.
b) Outpatient	20% coinsurance after deductible. Speech therapy is limited to 60 visits per member in each benefit year, in- and out-of-network combined, except for children to age 6.	40% coinsurance after deductible. Speech therapy is limited to 60 visits per member in each benefit year, in- and out-of-network combined, except for children to age 6.
22. DURABLE MEDICAL EQUIPMENT	20% coinsurance after deductible. See policy for types and circumstances of coverage.	40% coinsurance after deductible. See policy for types and circumstances of coverage.
	For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare.	
23. OXYGEN	20% coinsurance after deductible	40% coinsurance after deductible
24. ORGAN TRANSPLANTS	20% coinsurance after deductible. See policy for details.	40% coinsurance after deductible. See policy for details.
25. HOME HEALTH CARE	20% coinsurance after deductible.	40% coinsurance after deductible.
	Limited to 60 visits per member in each benefit year, in-and out-of-network combined.	
26. HOSPICE CARE		
a) Inpatient Care	20% coinsurance after deductible	40% coinsurance after deductible
b) Outpatient care	20% coinsurance. Limited to 91 visits per member in each benefit period, in-and out-of-network combined.	40% coinsurance after deductible. Limited to 91 visits per member in each benefit period, in-and out-of-network combined.
27. SKILLED NURSING FACILITY CARE	Not covered	Not covered
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Vision benefits included in this plan can be found on the separate Blue View Vision Summary Description.	
30. CHIROPRACTIC CARE	Not covered	Not covered

31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	$500 additional accident benefits per member per accident in allowed charges. Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams (20% coinsurance in network, 40% coinsurance out of network, after deductible). Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefits and subject to the prescription copayment. When a member desires another professional opinion, they may obtain a second surgical opinion.

PART C: LIMITATIONS AND EXCLUSIONS

32. **PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.** [10]	12 months for all pre-existing conditions unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.
33. **EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?**	Yes, unless the individual is a HIPAA-eligible individual as defined under federal and state law.
34. **HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?**	A pre-existing condition is an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health-care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.
35. **WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?**	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan, sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. **Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?**	No	Yes, the member is responsible for obtaining pre-certification unless the provider participates with Anthem Blue Cross and Blue Shield.
37. **Is prior authorization required for surgical procedures and hospital care (except in an emergency)?**	Yes	Yes, the member is responsible for obtaining pre-certification unless the provider participates with Anthem Blue Cross and Blue Shield.
38. **If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?**	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
39. **What is the main customer service number?**	(888) 231-5046	
40. **Whom do I write/call if I have a complaint or want to file a grievance?** [11]	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 (888) 231-5046	
41. **Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?**	**Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202**	
42. **To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.**	Policy form #'s 96319, individual	

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2] "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement."

[2a] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

[2b] "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

[3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

[4] Medical office visits include physician, mid-level practitioner, and specialist visits.

[5] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother if complication of pregnancy and well-baby together: there are not separate copayments.

[6] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

[7] "Emergency care" means all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb threatening emergency existed.

[8] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

[9] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[10] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

[11] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Anthem.

ANTHEM VISION SUMMARY PLAN DESCRIPTION

At Anthem Blue Cross & Blue Shield, we understand that vision benefits are essential to maintaining your overall health and well-being. After all, more than 65 percent of today's workforce wears eyeglasses or contact lenses. That is approximately 147 million people nation-wide, and the demand grows with each and every day.

Blue View Vision[SM], our vision program, provides a cost effective , comprehensive vision plan that includes eye examinations through a broad range of eye care providers and locations. The plan is easy to use and offers additional savings beyond exam coverage. Blue View Vision provides you with an innovative vision program to meet your unique needs and improve your overall wellness.

Anthem's Provider Network: **Blue View Vision** contracts with many providers, which includes independent optometrists and ophthalmologists as well as retail locations. Anthem members have access to approximately 44,000 conveniently located providers nationwide. Members may call Blue View Vision toll-free at 866-723-0515 or visit www.anthem.com any time for provider locations. Schedule an appointment with your Blue View Vision Network provider; identify yourself as a Blue View Vision member for fast, paperless determination and confirmation of benefits.

Network Provider: Maximum benefits are achieved when members access their benefits from a ***Blue View Vision*** Participating Provider. Copayment(s) may apply to in-network benefits.

Non-Network Provider Reimbursements: Members may go to a non-participating (non-network) provider and pay the provider directly for services and materials. Members may then submit an original itemized invoice and a copy of the prescription along with the Member's I.D. number to ***Blue View Vision*** for reimbursement according to the Non-Network Reimbursement schedule identified in this Summary Plan Description.

***Value Added Savings: Blue View Vision Network** Providers* offer you discount pricing, which is significantly below retail. You receive substantial savings (15%-40% or more) on most additional eyewear pair purchases, conventional contact lenses, lens treatments and various sundry items.

Anthem Vision Benefits	**Member Benefit from Network Provider**	**Non-Network Reimbursement****
Vision Examination**:* Each member is entitled to a comprehensive vision examination by a Blue View Vision Provider. ***Availability **: Once every 12 months***	**$25 Copayment**	**Up to $35**
Lenses: Standard plastic (CR39) lenses in single vision, and bifocal or trifocal (FT 25-28); lenses up to 55 mm; and all ranges of prescriptions.	**$25 Materials copayment applies to lenses**	
Single Vision Lenses	**$25 Copayment**	**Up to $25**
Bifocal Lenses (pair)	**$25 Copayment**	**Up to$40**
Progressive Lenses (pair)	**$90 Copayment**	**Up to$40**
Trifocal Lenses (pair)	**$25 Copayment**	**Up to $55**
Lenticular ***Availability*** **: Once every 12 months***	**$25 Copayment**	**Up to $80**
Frames: Maximum Allowable Amount of **$120** (retail value) for frames purchased from a Blue View Vision Network Provider. ***Availability*** **: Once every 24 months***	**$25 Copayment** Member pays amount in excess of Maximum Allowable Amount (retail value). 20% discount applies to the balance over the plan allowance.	**Up to $45**
Contact Lenses:*** **Elective -** Members have a **$105** plan allowance per benefit period toward cosmetic contact lenses *in lieu of the frame and lens benefits* from a Blue View Vision Network provider.	**No Copayment** If the member chooses contact lenses greater than the plan allowance, the member is responsible for the difference. Members receive 15% discount off balance over the plan allowance for conventional lenses. No discount applies to disposable contact lenses.	**Up to $80**
Non-Elective - Contact lenses prescribed for reasons that are not cosmetic in nature. ***Availability*** **: Once every 12 months***	**No Copayment**	**Up to $210**

From your last date of service

***** Non-Network Reimbursement represents Plan's allowance towards eligible benefits and may not cover all charges.***

******See Membership Certificate for definitions of Elective and Non-Elective Contact Lenses.***

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Limitations and Exclusions

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the Plan Design; however, these materials and any items not covered below may be purchased with our Additional Savings Program from a Blue View Vision Provider. In addition, benefits are payable only for expenses incurred while the individual Member coverage is in force.

Not Covered:

- Orthoptics or vision training and any supplemental testing.
- Plano (non- prescription) lenses.
- Two pair of eyeglasses in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eyes.
- An eye exam or corrective eyewear required by an employer as a condition of employment.
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related.
- Sub-normal vision aids.
- Plain or prescription sunglasses or tinted lenses, and no-line bifocals and blended lenses.
- Charges in excess of Usual and Customary for services and materials.
- Experimental or non-conventional treatments or devices.
- Safety eyewear.
- In conjunction with other offers or discounts.
- Spectacle lens styles, materials, treatments or "add-ons" not shown in the Summary Plan Description.

Anthem Blue Cross and Blue Shield & HMO Colorado
Health Benefit Plan Description Form Disclosure Amendment

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

Pursuant to Colorado law (C.R.S. §10-16-107(7)(a), services or supplies for the treatment of Intractable Pain and/or Chronic Pain are not covered.

This coverage is renewable at your option, except for the following reasons:

1. **Non-payment of the required premium;**
2. **Fraud or intentional misrepresentation of material fact on the part of the plan sponsor;**
3. **The commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations;**
4. **The carrier elects to discontinue offering and non-renew all of its individual plans delivered or issued for delivery in Colorado.**

Cancer Screenings

At Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado, Inc., we believe cancer screenings provide important preventive care that supports our mission: to improve the lives of the people we serve and the health of our communities. We cover cancer screenings as described below.

Pap Tests

All plans provide coverage for an annual Pap test and the related office visit. Payment for the Pap test is based on the plan's laboratory services provisions, and payment for the related office visit is based on the plan's preventive care provisions. With our BluePreferred for Individuals PPO Plan, laboratory services for a Pap test are limited to a maximum payment of $75.00. With our Colorado HSA-Qualified Plans for Individuals, all services related to a Pap test are subject to the maximum benefit as described on the Health Benefit Plan Description Form. Under most plans pap tests received out of-network are not covered.

Mammogram Screenings

All plans except our HMO and PPO Basic Health Plans provide mammogram screening coverage for women 35 years of age and older. Frequency guidelines can be found in your certificate. Payment for the mammogram screening benefit is based on the plan's provisions for X-ray services. Our HMO and PPO Basic Health Plans do not provide coverage for mammogram screenings.

Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide prostate cancer screening coverage for men 40 years of age and older. Frequency guidelines can be found in your certificate. Payment for the prostate cancer screening benefit is based on the plan's provisions for X-ray services. Our HMO and PPO Basic Health Plans do not provide coverage for prostate cancer screenings.

Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for colorectal cancer screenings, such as colonoscopies, sigmoidoscopies and fecal occult blood tests. Depending on the type of colorectal cancer screening received, payment for the benefit is based on the plan's provisions for laboratory services, preventive care office visit services, or other medical or surgical services. Our plans do not provide coverage for preventive colorectal cancer screenings involving invasive surgical procedures and DNA analysis. Under most plans colorectal cancer screenings received out of-network are not covered.

The information above is only a summary of the benefits described. The certificate for each health plan includes important additional information about limitations, exclusions and covered benefits. The Health Benefit Plan Description Form for each health plan includes additional information about copayments, deductibles and coinsurance. If you have any questions, please call our customer service department at the phone number on the Health Benefit Plan Description Form.